



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

American Specialty Pharmacy

Respondent Name

FedEx Freight, Inc.

MFDR Tracking Number

M4-16-0229-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Submitted documentation does not find a position statement from the requestor.

Amount in Dispute: \$74.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier is processing for proper payment."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 3, 2015	Prescription Medication (Tramadol HCl)	\$74.20	\$66.66

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.503 sets out the guidelines for billing and reimbursing pharmaceutical services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - F – Reduced according to fee guideline

Issues

1. What is the total reimbursement for the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The total reimbursement for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503 (c), which states,
 - (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
 - (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
 - (A) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
 - (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
 - (A) health care provider...

The requestor is seeking reimbursement for the generic drug Tramadol HCl, NDC 16714011112. The disputed medication was dispensed on July 3, 2015. The reimbursement is calculated as follows:

Date of Service	Prescription Drug	Calculation per §134.503 (c)(1)	§134.503 (c)(2)	Lesser of §134.503 (c)(1) & (2)	Carrier Paid	Balance Due
7/3/15	Tramadol HCl	$(0.83545 \times 60 \times 1.25) + \$4.00 = \$66.66$	\$74.20	\$66.66	\$0.00	\$66.66

2. The total reimbursement amount for the disputed service is \$66.66. The insurance carrier paid \$0.00. An additional reimbursement of \$66.66 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$66.66.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$66.66 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	December 17, 2015 _____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.